



For up to date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

Fax requests to 1 800 609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4

This facsimile is Doctor-Patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited. If you have received this fax in error, please write "MIS-DIRECTED" across the front of the form and fax toll-free to 1 800 609-4884, then destroy the pages received in error.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested medication is, or is not, suitable for any specific patient or condition.

Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.

SECTION 1 - RHEUMATOLOGIST INFORMATION

Form for Section 1 containing fields for Prescriber's Name and Mailing Address, Mail Confirmation, College ID, MSP Number, Phone Number, and Prescriber's Fax Number. Includes a 'CRITICAL FOR A TIMELY RESPONSE' warning.

SECTION 2 - PATIENT INFORMATION

Form for Section 2 containing fields for Patient (Family) Name, Patient (Given) Name(s), Date of Birth, Date of Application, and Personal Health Number (PHN). Includes a 'CRITICAL FOR PROCESSING' warning.

SECTION 3 - MEDICATION REQUESTED

Form for Section 3 containing medication options: ADALIMUMAB 9901-0152, CERTOLIZUMAB 9901-0126, ETANERCEPT, GOLIMUMAB 9901-0121, and INFLIXIMAB. Includes fields for dose, interval, body weight, and start date. Includes a note: 'If approved, please note that claims with indefinite SA approvals will be monitored and any overuse or significant underuse will be subject to review.'

SECTION 4 - CURRENT CLINICAL INFORMATION

Form for Section 4 containing fields for ESR or CRP, Morning Stiffness (minutes), and Physician Global Assessment of Inflammation (scale of 0-10).

PHARMACARE USE ONLY

Please complete additional information on page 2 >>

Form for Pharmacare Use Only containing fields for Status, Effective Date, and Duration of Therapy / Termination Date.

# ADALIMUMAB / CERTOLIZUMAB / ETANERCEPT / GOLIMUMAB / INFLIXIMAB FOR PSORIATIC ARTHRITIS

PATIENT NAME	PHN	DATE (YYYY / MM / DD)
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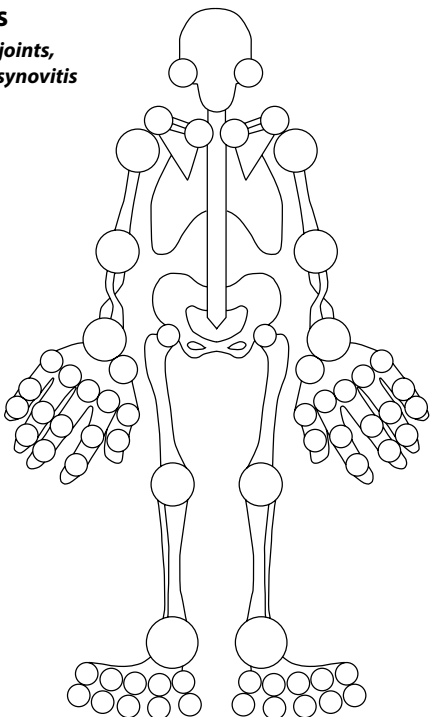
## SECTION 5 - CURRENT MEDICATIONS (DMARDs, anti-inflammatories, corticosteroids, analgesics, opioids)

DRUG	DOSE	FREQUENCY

## SECTION 6 - CRITERIA FOR RENEWAL

<b>A</b> Status of cutaneous psoriasis: <input type="checkbox"/> Never Present <input type="checkbox"/> Resolved <input type="checkbox"/> Not Resolved →	<b>If not resolved:</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
<b>B</b> For the criteria <b>originally specified</b> in the request for initial coverage, please provide current status.	<b>IMPROVEMENT</b>	
	RESOLVED	NOT RESOLVED (ADDITIONAL COMMENTS IF APPLICABLE)
	Five or more swollen joints ( <b>please complete homunculus below</b> )	
	Oligoarthritis ( <b>please complete homunculus below</b> )	
	Dactylitis ( <b>indicate by arrow and "D" on homunculus below</b> )	
	Tenosynovitis ( <b>indicate by arrow and "TS" on homunculus below</b> )	
	Enthesitis ( <b>indicate by arrow and "E" on homunculus below</b> )	
	Inflammatory spinal symptoms (submit current BASDAI)	
	Daily use of corticosteroids to control active arthritis.	
Use of narcotics for pain resulting from inflammation	DRUG	CURRENT DOSE
<input type="checkbox"/> Functional assessment completed by patient and attached <input type="checkbox"/> Health Assessment Questionnaire (HAQ) <b>AND/OR</b> <input type="checkbox"/> BASDAI (in spinal disease)		
ADDITIONAL COMMENTS REGARDING PATIENT'S CURRENT MEDICAL STATUS		

**HOMUNCULUS**  
*Indicate active joints, dactylitis, tenosynovitis and enthesitis*



**Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).**

<p>Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the <i>British Columbia Pharmaceutical Services Act</i> and <i>Freedom of Information and Protection of Privacy Act</i>. It will not be disclosed to any persons without the patient's consent. The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the medication requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally. If you have any questions about the collection or use of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.</p> <p>I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.</p> <p style="text-align: right;">_____</p> <p>Rheumatologist's Signature (Mandatory)</p>
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*PharmaCare may request additional documentation to support this Special Authority request. Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.*